



**Department of Veterans Affairs  
Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 09-02287-215**

# **Combined Assessment Program Review of the VA Loma Linda Healthcare System Loma Linda, California**



**September 17, 2009**

**Washington, DC 20420**

## **Why We Did This Review**

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care is provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections and Investigations to provide collaborative assessments of VA medical facilities on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical services.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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## Executive Summary

### Introduction

During the week of July 20–23, 2009, the OIG conducted a Combined Assessment Program (CAP) review of the VA Loma Linda Healthcare System (the system), Loma Linda, CA. The purpose of the review was to evaluate selected operations, focusing on patient care administration and quality management (QM). During the review, we also presented fraud and integrity awareness training to 587 system employees. The system is part of Veterans Integrated Service Network (VISN) 22.

### Results of the Review

The CAP review covered seven operational activities. We also followed up on three activities from the prior CAP review. We identified the following organizational strengths and reported accomplishments:

- Breast Cancer Care Collaborative.
- All Employee Survey (AES) Scores.
- Rapid Response Team (RRT).

We made recommendations in four of the activities reviewed. For these activities, the system needed to:

- Require that peer review processes comply with Veterans Health Administration (VHA) requirements.
- Ensure current life support training or certification for designated trainees and employees and revise system policy to ensure actions are specified and taken when life support training or certification has expired.
- Include physicians in the medical record quality review process and continue the recently implemented monitoring of the copy and paste functions.
- Ensure that physician privileging processes comply with VHA requirements for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE).
- Address identified deficiencies in magnetic resonance imaging (MRI) safety.
- Address identified training deficiencies.

The system complied with selected standards in the following three activities:

- Contracted/Agency Registered Nurses (RNs).
- Coordination of Care.
- Medication Management.

This report was prepared under the direction of Daisy Arugay, Associate Director, Los Angeles Regional Office of Healthcare Inspections.

## Comments

The VISN and System Directors agreed with the CAP review findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 16–21, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

*(original signed by:)*

JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
Healthcare Inspections

## Introduction

### Profile

**Organization.** The system is a tertiary care facility located in Loma Linda, CA, that provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at five community based outpatient clinics in Corona, Palm Desert, Sun City, Upland, and Victorville, CA. The system is part of VISN 22 and serves a veteran population of about 285,000 throughout San Bernardino and Riverside Counties.

**Programs.** The system provides primary care and inpatient services. It has 142 hospital beds and 108 community living center (CLC) beds.<sup>1</sup>

**Affiliations and Research.** The system is affiliated with Loma Linda University's School of Medicine and provides training for more than 1,200 medical residents, fellows, and students. It also has numerous other affiliations to provide training for other disciplines, including nursing, pharmacy, and social work. In fiscal year (FY) 2008, the system research program had 136 projects and a budget of \$5.6 million. Important areas of research included hearing loss; heart disease and hypertension; molecular genetics; and tissue, nerve, and bone regeneration. In addition, the system serves as the Institutional Review Board of record for the VA Southern Nevada Healthcare System, which has 21 active research projects.

**Resources.** In FY 2008, medical care expenditures totaled more than \$398 million. The FY 2009 medical care budget is over \$412 million. FY 2008 staffing was 1,995 full-time employee equivalents (FTE), including 145 physician and 470 nursing FTE.

**Workload.** In FY 2008, the system treated 58,301 unique patients and provided 44,641 inpatient days in the hospital and 33,405 inpatient days in the CLC. The inpatient care workload totaled 8,365 discharges. The inpatient average daily census (ADC) was 122, and the CLC ADC was 91. Outpatient workload totaled 546,017 visits.

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<sup>1</sup> A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

## Objectives and Scope

**Objectives.** CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care administration and QM.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

**Scope.** We reviewed selected clinical and administrative activities to evaluate the effectiveness of patient care administration and QM. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and conditions.

In performing the review, we inspected work areas; interviewed managers and employees; and reviewed clinical and administrative records. The review covered the following seven activities:

- Contracted/Agency RNs.
- Coordination of Care.
- Environment of Care (EOC).
- Medication Management.
- MRI Safety.
- Physician Credentialing and Privileging (C&P).
- QM.

The review covered system operations for FY 2008 and FY 2009 through July 2009 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on recommendations from our prior CAP review of the system (*Combined Assessment Program Review of the VA Loma Linda Healthcare System, Loma Linda, California*, Report No. 06-01287-196, August 24, 2006). We had identified improvement opportunities in the following activities: (1) Community Nursing Home Evaluations, (2) Diabetes and Atypical

Antipsychotic Medications, and (3) Breast Cancer Management. During our follow-up review, we found sufficient evidence that program managers and staff had implemented appropriate actions to address the identified deficiencies in these areas. We consider these issues closed.

During this review, we also presented fraud and integrity awareness briefings to 587 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. The activities in the "Review Activities Without Recommendations" section have no reportable findings.

## Organizational Strengths

### Breast Cancer Care Collaborative

The system is one of three facilities selected in FY 2009 to participate in the national VHA Cancer Care Collaborative program to improve care and services for patients with breast cancer. Program managers focused their efforts on the timeliness of imaging services and implemented improved procedures to reduce wait times for mammography scheduling and tissue diagnosis (biopsy). As of the end of the 3<sup>rd</sup> quarter of FY 2009, the system has realized a wait time reduction of 92 percent for mammography scheduling (from a mean of 36 days to 3 days), 74 percent from positive mammogram to ultrasound guided biopsy (from a mean of 39 days to 8 days), and 44 percent from positive mammogram to stereotactic biopsy<sup>2</sup> (from a mean of 54 days to 30 days). In addition, the system is implementing a navigator program that will allow dedicated program staff to guide patients as they undergo breast cancer treatments.

### All Employee Survey Scores

Since 2006, the AES has been administered to VHA employees annually to assess employee satisfaction and organizational health. The system's national AES scores from 2007 through 2009 have consistently exceeded the VISN and national scores in the area of job satisfaction. The

<sup>2</sup> A stereotactic biopsy is used take samples from a lump that cannot be felt during a breast exam but can be seen on a mammogram or an ultrasound.

system's employee satisfaction is among the highest nationally in VA. Also, while the national response rate goal for the 2009 AES was 72 percent, the system's response rate was 85 percent, which exceeded both VISN and national response rates.

### **Rapid Response Team**

In 2007, the system established an RRT to improve patient outcomes by employing timely response to changes in a patient's condition. Since its implementation, the RRT has helped reduce the number of "Code Blues" (cardiorespiratory arrests), provided interim care to patients awaiting transfer to the critical care unit, and improved communication between inpatient units by providing education and establishing a positive relationship with unit staff. The RRT has also assisted with intravenous insertions and helped facilitate timely discharge of patients. The RRT's achievements will be highlighted through a poster presentation at an upcoming 2009 VHA national conference.

## **Results**

### **Review Activities With Recommendations**

#### **Quality Management**

The purpose of this review was to evaluate whether the system's QM program provided comprehensive oversight of the quality of care and whether senior managers actively supported the program's activities. We interviewed the system's Director and Chief of Staff (COS). We also interviewed QM personnel and several service chiefs. We evaluated plans, policies, and other relevant documents. The QM program was generally effective in providing oversight of the system's quality of care. However, we identified three areas that needed improvement.

Protected Peer Review. VHA requires specific processes to ensure a robust and timely protected peer review program.<sup>3</sup> We noted that peer reviews were appropriately assigned, completed, and discussed at Peer Review Committee (PRC) meetings. However, timeliness of the initial review could be improved. The rate of completion within the required 45 days was 81 percent for the 2<sup>nd</sup> quarter of FY 2009. In each case, extensions were requested and granted by the COS.

<sup>3</sup> VHA Directive 2008-004, *Peer Review for Quality Management*, January 28, 2008.

VHA also requires that peer review trend reports be presented to the Medical Executive Council (MEC) quarterly, but only one such report was presented from May 2008 through May 2009. Several action items resulting from peer review discussions, such as better identifying and documenting serious infections, had not been completed timely.

Additionally, VHA requires that clinicians inform veterans who experience serious adverse events about the situation and, if appropriate, explain their right to file tort or disability claims. It did not appear that adverse events identified through the peer review process were considered for disclosure to the veterans or their family members.

**Recommendation 1**

We recommended that the VISN Director ensure that the System Director requires that peer review processes comply with VHA requirements.

The VISN and System Directors agreed with the findings and recommendation. The system revised its peer review reporting process. In addition, the PRC will present quarterly trend reports to the MEC, and PRC meeting minutes will indicate whether Level 2 and 3 reviews should be considered for disclosure. Target date for completion is January 1, 2010. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Life Support Training. Basic Life Support (BLS) training was required by system policy for a number of trainees and employees, including medical residents, RNs, and respiratory therapists. Advanced Cardiac Life Support (ACLS) certification was required for clinicians working in the intensive care areas and the emergency department. Some employees in several services were not current with their BLS or ACLS training or certification. We concluded that the tracking of this important training function was inadequate. The tracking process did not note actions taken when training or certification had expired. Additionally, the policy noted only vague actions that were to result from failure to maintain current training or certification and needed to be revised.

**Recommendation 2**

We recommended that the VISN Director ensure that the System Director requires that life support training or

certification is current for designated trainees and employees and that system policy is revised to ensure that appropriate actions are specified and taken when life support training or certification has expired.

The VISN and System Directors agreed with the findings and recommendation. System policy will be updated to clarify training requirements. In addition, the tracking process will be updated to ensure timely renewal of training or certification. Target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Medical Record Review. VHA regulations<sup>4</sup> and accreditation standards require that facilities have a systematic medical record quality review process. We noted that a comprehensive review process was in place. However, although several clinical disciplines were involved in the review process, physicians were not included. Also, required monitoring of the copy and paste functions in the electronic medical record had not been in place from May 2008 through May 2009; monitoring began in June 2009.

### **Recommendation 3**

We recommended that the VISN Director ensure that the System Director requires that the medical record quality review process include physicians and that the recently implemented monitoring of the copy and paste functions be continued.

The VISN and System Directors agreed with the findings and recommendation. The system will modify its OPPE process to include physician medical record review, and the newly implemented monitoring of the copy and paste functions will continue. Target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

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<sup>4</sup> VHA Handbook 1907.01, *Health Information Management and Health Records*, August 25, 2006.

## **Physician Credentialing and Privileging**

The purpose of this review was to determine whether VHA facilities have consistent processes for physician C&P. For a sample of physicians, we reviewed selected VHA required elements in C&P files and provider profiles.<sup>5</sup> We also reviewed meeting minutes during which discussions about the physicians took place.

We reviewed 10 physicians' C&P files and profiles from various services and found that licenses were current and that primary source verification had been appropriately obtained. However, we identified the following areas that needed improvement.

FPPE. Also known as proctoring, FPPE is a review process to ensure the competence of newly hired physicians. The written plan was thorough and had been appropriately applied to newly hired physicians over the past 12 months. However, the time periods for the physicians' FPPEs were not clearly designated. Also, the results of FPPEs were not always documented on the FPPE form or in MEC meeting minutes.

OPPE. VHA regulations also require a thorough written plan with specific competency criteria for OPPE for all privileged physicians. Neither the written plan nor the OPPE forms included service-specific competency criteria. In addition, two of the eight physician profiles subject to OPPE did not have evidence of any OPPE data for the designated 6-month evaluation periods. Also, MEC meeting minutes discussed individual competence based on continuing medical education and peer reports but did not reflect detailed discussion of physicians' performance data prior to reprivileging. Additionally, we noted several irregularities on the OPPE forms (blank signature blocks and unchecked boxes); these were corrected immediately.

### **Recommendation 4**

We recommended that the VISN Director ensure that the System Director requires that physician privileging processes are in compliance with VHA requirements for FPPE and OPPE.

The VISN and System Directors agreed with the findings and recommendation. The system will update its OPPE plan to include service-specific monitors and will ensure that forms are complete. Appropriate meeting minutes will be

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<sup>5</sup> VHA Handbook 1100.19, *Credentialing and Privileging*, November 14, 2008.

attached to MEC minutes to provide more detailed information for FPPE and OPPE. Target date for completion is September 30, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

## **Magnetic Resonance Imaging Safety**

The purpose of this review was to evaluate whether the system maintained a safe environment and safe practices in the MRI area. Safe MRI procedures minimize risk to patients, visitors, and staff and are essential to quality patient care. VHA's MRI safety policy is detailed in an online resource guide that establishes requirements for safe MRI practices.<sup>6</sup>

We inspected the MRI area, examined patient and employee records, reviewed relevant policies, and interviewed key personnel. We noted that patients are directly observed during an MRI exam. Two-way communication is available between the patient and the MRI technologist, and patients have access to a push-button call system. In addition, we found readily available MRI-safe equipment. However, we identified five areas that needed improvement.

System Policy. The system did not have a written safety policy delineating safe practice guidelines. While we were onsite, Imaging Service managers provided us with a draft copy of the newly developed policy; however, it did not accurately address appropriate supervision of non-MRI personnel in the MRI area. Managers made the necessary corrections and assured us that the policy would be implemented once approved.

## **Recommendation 5**

We recommended that the VISN Director ensure that the System Director requires Imaging Service managers to implement the newly developed MRI safety policy.

The VISN and System Directors agreed with the findings and recommendation. The system has implemented the new policy. The corrective action is acceptable, and we consider this recommendation closed.

Risk Assessment. The Joint Commission (JC) requires facilities to identify safety and security risks associated with

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<sup>6</sup> VA, "Radiology Online Guide," <<http://vaww1.va.gov/Radiology/page.cfm?pg=167>>, updated December 20, 2007, Secs. 4.1–4.3.

the EOC. The system has two MRI scanners. Because of the limited space and the unique design of the MRI suite, the system had not fully complied with the four-zone concept defined by the American College of Radiology's safe practice guidelines. Presently, unscreened individuals have access to the restricted area (Zone III). We noted that additional safety barriers should be implemented to prevent unscreened or unauthorized individuals from gaining access to Zone III through the main entrance or hallway doors. Also, we determined that the Imaging Service needed to conduct a comprehensive risk assessment of the MRI area to identify and address safety vulnerabilities. Imaging Service managers agreed and told us that they plan to install a ferromagnetic detector<sup>7</sup> to supplement existing safety procedures.

#### **Recommendation 6**

We recommended that the VISN Director ensure that the System Director requires Imaging Service managers to conduct a comprehensive risk assessment of the MRI area and implement additional safety measures as applicable.

The VISN and System Directors agreed with the findings and recommendation. A multidisciplinary team has been formed to conduct the required assessment. Additional safety measures will be implemented as appropriate. The improvement plan is acceptable, and we will follow up on the planned actions until they are completed.

Training. MRI and non-MRI personnel who have daily or periodic access to the MRI area are required to receive appropriate MRI safety training. We reviewed nine MRI technologists' training records, and all had current safety training. However, other MRI staff (radiologists, clerical support, and a supervisor) had not completed the necessary training. In addition, until 1 week prior to our site visit, there was no evidence of initial or ongoing annual training for non-MRI staff (such as housekeeping staff, supply and processing staff, police officers, and code team members) who have access to the area. Managers agreed that training for these individuals had not been consistent. They plan to implement an automated tracking process to ensure compliance.

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<sup>7</sup> A device that is used to identify materials that threaten patient safety and magnet operation.

**Recommendation 7**

We recommended that the VISN Director ensure that the System Director requires that personnel who have access to the MRI area complete safety training, as required.

The VISN and System Directors agreed with the findings and recommendation. The required MRI training has been initiated. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

Screening. MRI technologists are required to screen patients undergoing an MRI using a standard screening questionnaire. Any positive (“yes”) response must be addressed before the patient is scanned. Of the 15 patient records reviewed, 2 (13 percent) contained positive responses. We did not find documented evidence that the positive responses were addressed.

**Recommendation 8**

We recommended that the VISN Director ensure that the System Director requires MRI technologists to follow up on positive responses on the screening questionnaire and document actions taken to address potentially dangerous conditions that were identified.

The VISN and System Directors agreed with the finding and recommendation. Immediately after the CAP review, the system implemented a new policy requiring MRI technologists to take action on any positive response to the questionnaire. An audit form was created, and the MRI supervisor is conducting random audits for compliance. The corrective actions are acceptable, and we consider this recommendation closed.

Informed Consent. Patients with impaired renal functions who are undergoing an MRI exam with gadolinium (a contrast media that is used to enhance the image quality of the exam) are required to sign informed consents that address the increased risk and alternatives to the contrast media. We reviewed the medical records of five high-risk patients. We found signed consents. However, the consents did not include the risks associated with the use of gadolinium. Imaging Service managers agreed that the consents were insufficient and told us that they are presently installing an electronic consent form that will address the risks of gadolinium for high-risk patients.

## **Recommendation 9**

We recommended that the VISN Director ensure that the System Director requires Imaging Service managers to develop appropriate consent forms for high-risk patients undergoing an MRI exam with contrast media.

The VISN and System Directors agreed with the finding and recommendation. The system has implemented electronic consent signature pads in the MRI and will obtain informed consent from all high-risk patients. The corrective actions are acceptable, and we consider this recommendation closed.

## **Environment of Care**

The purpose of this review was to determine if the system maintained a clean, safe, and secure environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National center for Patient Safety, Occupational Safety and Health Administration, National Fire Protection Association, and JC standards.

We inspected the ambulatory care clinics, the hemodialysis unit, the gastroenterology clinic, and all inpatient units. We also inspected the clinical laboratory and the emergency department. Overall, we found the areas we inspected to be clean and well maintained.

We identified several concerns that required managers' attention, such as unprotected patient information, infection control and general maintenance issues, and obstructed hallways. Managers took immediate actions to correct these deficiencies. Therefore, we did not make any recommendations related to these findings. However, we identified the following condition that needed improvement.

Training. VHA policy<sup>8</sup> requires employees on the locked inpatient mental health (MH) unit and members of the Multidisciplinary Safety Inspection Team (MSIT) to complete training on environmental hazards that represent a threat to suicidal patients. None of the 51 MH unit staff and only one of the five MSIT members received training on identifying and correcting environmental hazards specific to this unit. While we were onsite, managers initiated training for these employees.

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<sup>8</sup> Deputy Under Secretary for Health for Operations and Management, "Mental Health Environment of Care Checklist," memorandum, August 27, 2007.

In addition, we examined the infection control training records of 58 employees from one inpatient unit and one outpatient clinic. We found that 16 (28 percent) employees had not completed the required training.

**Recommendation 10**

We recommended that the VISN Director ensure that the System Director addresses the identified training deficiencies.

The VISN and System Directors agreed with the findings and recommendation. The system plans to complete all required training by October 1, 2009. The improvement plans are acceptable, and we will follow up on the planned actions until they are completed.

### **Review Activities Without Recommendations**

**Contracted/Agency  
Registered Nurses**

The purpose of this review was to evaluate whether RNs working in VHA facilities through contracts or temporary agencies met the same entry requirements as RNs hired as part of VHA facility staff. The system utilized one agency RN during the past 12 months. We reviewed documents for several required components, including licensure, training, and competencies. We found that system managers had appropriate processes in place and followed them consistently; therefore, we made no recommendations.

**Coordination of  
Care**

The purpose of this review was to evaluate whether inpatient intra-facility transfers, discharges, and post-discharge MH care were coordinated appropriately over the continuum of care and met VHA and JC requirements. Coordinated transfers, discharges, and post-discharge MH care are essential to optimal patient outcomes.

We reviewed the documentation for intra-facility transfers and determined that clinicians appropriately managed 22 (96 percent) of 23 transfers. Also, we reviewed the medical records of 25 patients who were discharged and found that all patients received appropriate written discharge instructions. We also found documentation that the patients understood those instructions.

Additionally, we reviewed the medical records of four patients recently discharged from the acute MH unit. We found documentation that patients received information on how to access emergency MH care and that patients were

given MH clinic appointments within 2 weeks of discharge. We also found that MH providers either arranged for follow-up appointments or contacted the patients by phone within 7 days of discharge. We made no recommendations.

## **Medication Management**

The purpose of this review was to determine whether VHA facilities had developed effective and safe medication management practices. We reviewed selected medication management processes on the inpatient medicine/surgery, MH, and CLC units.

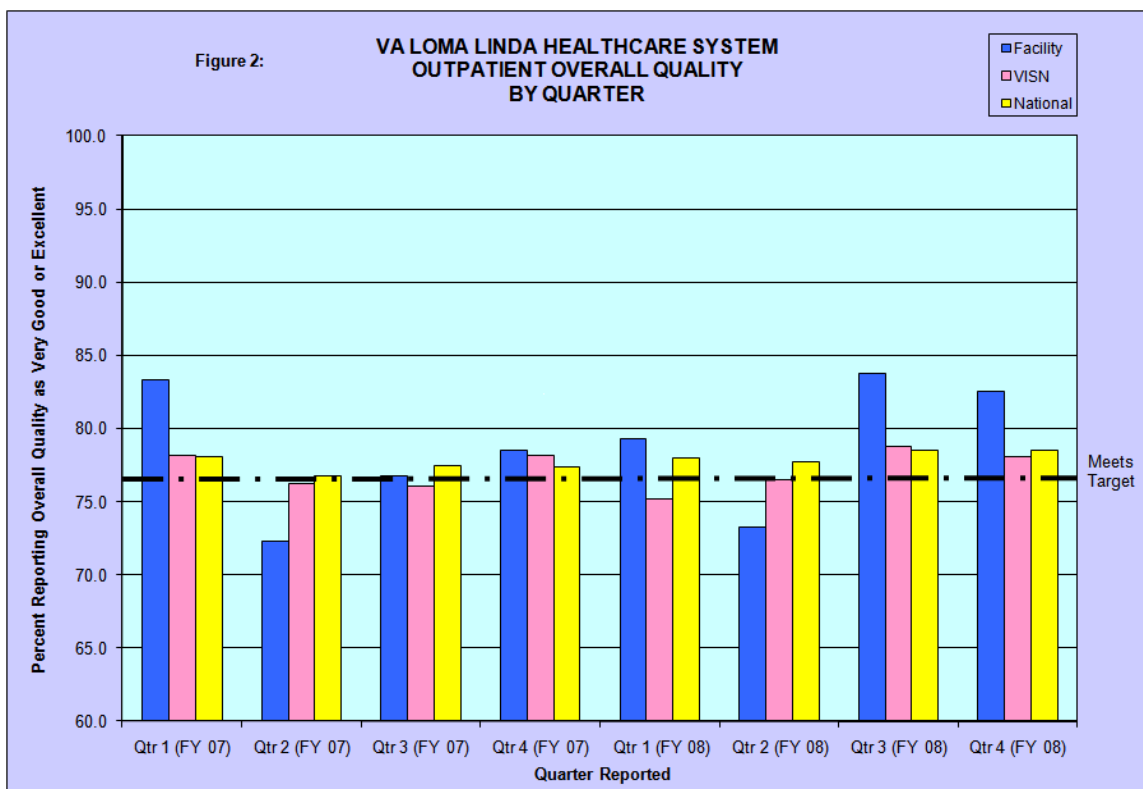
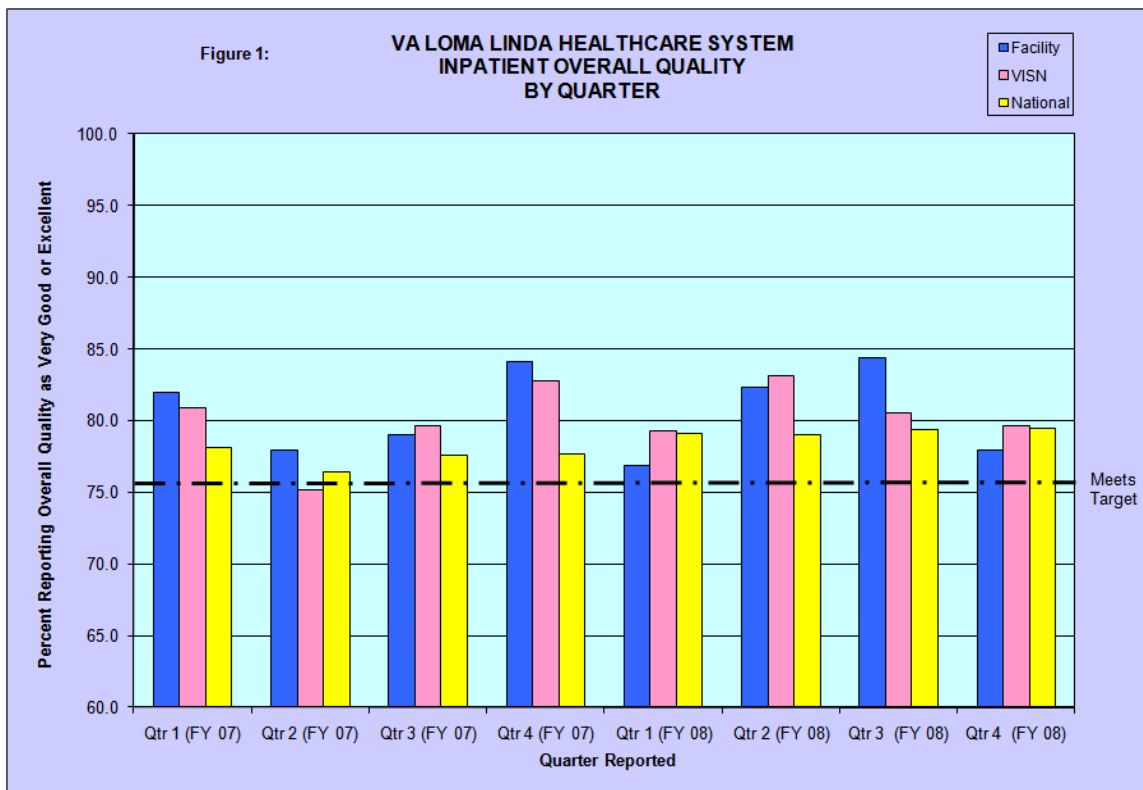
The system has a designated Bar Code Medication Administration (BCMA) Program coordinator who had appropriately identified and addressed problems. We found evidence of several monitoring activities to improve BCMA procedures; however, there was no formal BCMA performance improvement (PI) plan. We suggested that the system develop a formal PI plan.

Also, we found evidence that patients were assessed for pain. However, documentation of the effectiveness of pain medications did not generally occur until the “end of shift” (up to 12.5 hours), which was in accordance with system policy. We reviewed the medical records for patients from all inpatient nursing units and found them to be in compliance with system policy.

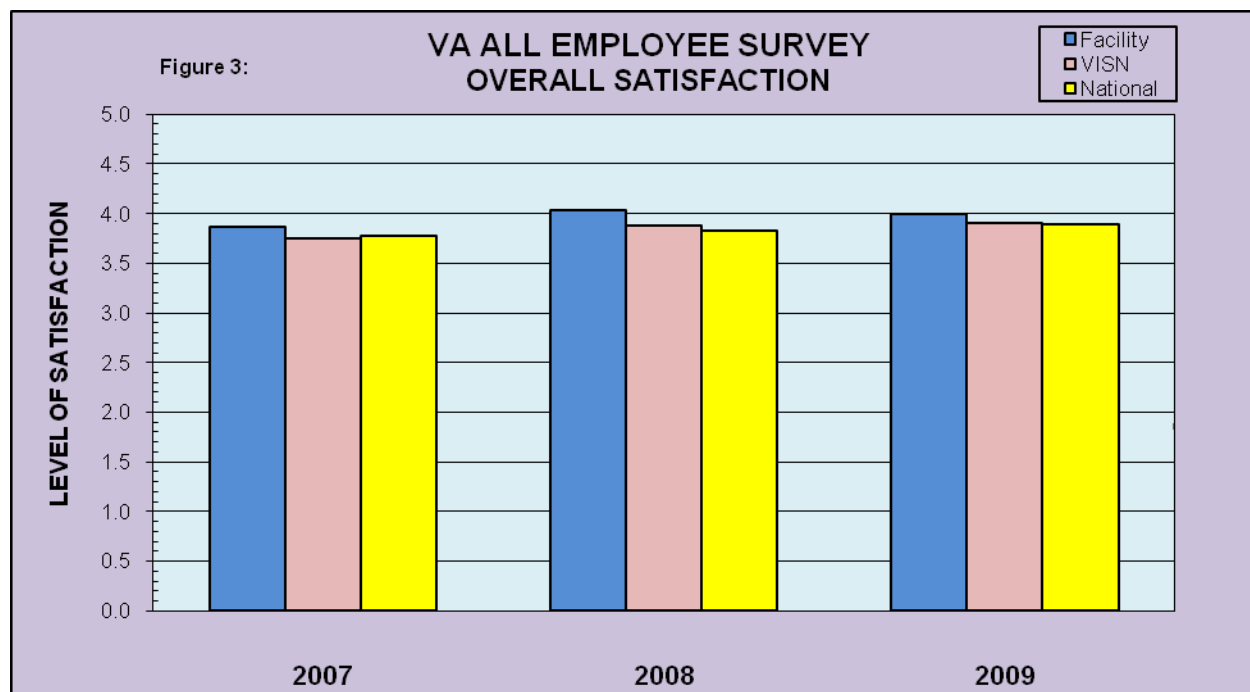
We also reviewed 10 CLC patients’ medical records to determine if pharmacy staff had conducted monthly medication reviews. We found overall compliance with the required monthly reviews. Also, although the pharmacy is closed from 12:00 a.m. to 6:30 a.m. daily, we found that the system had appropriately provided a qualified pharmacist to answer questions during those hours. We made no recommendations.

## **VHA Satisfaction Surveys**

VHA has identified patient and employee satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly, and data are summarized quarterly. Figures 1 and 2 on the next page show the system, VISN, and national overall inpatient and outpatient satisfaction scores for FYs 2007 and 2008. Target scores are noted on the graphs.



Employees are surveyed annually. Figure 3 below shows the system's overall employee scores for 2007, 2008, and 2009. Since no target scores have been designated for employee satisfaction, VISN and national scores are included for comparison.



## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** August 25, 2009

**From:** Director, VA Desert Pacific Healthcare Network (10N22)

**Subject:** Combined Assessment Program Review of the VA Loma Linda Healthcare System, Loma Linda, California

**To:** Director, Los Angeles Office of Healthcare Inspections (54LA)

**Thru:** Director, Management Review Service (10B5)

Please find attached VA Loma Linda Healthcare System's response to the Combined Assessment Program (CAP) survey recommendations conducted July 20–23, 2009.

The Network Office is in concurrence with the response.

If you have any questions, please contact John Tryboski, QMO, at 562-826-5963.

Sincerely,

A handwritten signature in black ink, appearing to read 'Ron Norby', with a stylized flourish at the end.

Ronald B. Norby,  
Network Director

## System Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** August 24, 2009  
**From:** Director, VA Loma Linda Healthcare System (605/00)  
**Subject:** Combined Assessment Program Review of the VA Loma Linda Healthcare System, Loma Linda, California  
**To:** Director, VA Desert Pacific Healthcare Network (10N22)

Please find attached VA Loma Linda Healthcare System's response to the Combined Assessment Program (CAP) survey recommendations conducted July 20–23, 2009.

If you require any further information or clarification, please contact me or Shane Elliott, Associate Director for Administration, at (909) 583-6002.

Sincerely,



*(original signed by:)*  
Donald F. Moore, R.Ph., MBA  
Medical Center Director

## **Comments to Office of Inspector General's Report**

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General report:

### **OIG Recommendations**

**Recommendation 1.** We recommended that the VISN Director ensure that the System Director requires that peer review processes comply with VHA requirements.

**Concur**

**Planned Actions: See below.**

1. M&M reviews will no longer be included in the Peer Review cycle as many are completed outside of the 45-day time limit. When Levels 2 and 3 are identified through M&M, those reviews will be entered into the Peer Review cycle and sent for re-review with a 45-day time limit.

**Target date of completion:** September 1, 2009

2. Trend reports will continue to be presented to the Medical Executive Council Quarterly; the MEC has received Peer Review reports for first and second quarters of FY09 (in March and June, 2009). The Peer Review committee will continue to make quarterly reports to MEC (ongoing) with four quarters of Peer Review committee reports completed by end of December 09. The Peer Review Committee will continue to report to the MEC quarterly (ongoing).

**Target date of completion:** January 1, 2010

3. To date, no adverse events have been identified through the Peer Review process that have not previously been disclosed to the patient/family. Starting in September 2009, Peer Review minutes will indicate whether or not disclosure should be considered on level 2 and 3 reviews.

**Target date of completion:** September 30, 2009

**Recommendation 2.** We recommended that the VISN Director ensure that the System Director requires that life support training or certification is current for designated trainees and employees and that the system policy is revised to ensure that appropriate actions are specified and taken when life support training or certification has expired.

**Concur.**

**Target date of completion:** September 30, 2009

**Planned Action:** Update HCS Policy to include actions for failure to maintain BLS and/or ACLS. Update tracking system to ensure timely receipt and renewal of BLS and/or ACLS as indicated by HCS Policy.

**Recommendation 3.** We recommended that the VISN Director ensure that the System Director requires that the medical record quality review process include physicians and that the recently implemented monitoring of the copy and paste functions be continued.

**Concur.**

**Target date of completion:** September 30, 2009

**Planned Action:** Modify the OPPE process to include MD medical record review as part of the every 6 month review. Continue copy and paste medical record review as implemented.

**Recommendation 4.** We recommended that the VISN Director ensure that the System Director requires that physician privileging processes are in compliance with VHA requirements for FPPE and OPPE.

**Concur.**

**Target date of completion:** September 30, 2009.

**Planned Action:** Update OPPE program to include service specific monitors with appropriate aggregate data. Ensure all forms are complete, including time frames and check boxes. As recommended, add PSB minutes as an attachment to MEC minutes to provide more detailed information regarding OPPE/FPPE.

**Recommendation 5.** We recommended that the VISN Director ensure that the System Director requires Imaging Service managers to implement the newly developed MRI safety policy.

**Concur.**

**Target date of completion:** August 24, 2009

**Planned Action:** Imaging Service's MRI Safety Plan has been implemented.

**Recommendation 6.** We recommended that the VISN Director ensure that the System Director requires Imaging Service managers to conduct a

comprehensive risk assessment of the MRI area and implement additional safety measures as applicable.

**Concur.**

**Target date of completion:** September 9, 2009

**Planned Action:** Risk Assessment Team (Patient Safety Manager; Safety Officer; Chief, Bio Med; MRI Supervisor) are gathering the appropriate forms to complete the assessment on September 9th. Additional safety measures will be implemented, as indicated.

**Recommendation 7.** We recommended that the VISN Director ensure that the System Director requires that personnel who have access to the MRI area complete safety training, as required.

**Concur.**

**Target date of completion:** September 11, 2009

**Planned Action:** Nursing, Safety, FMS, and Medical Residents have been provided the Level I power point and post-test as well as the MRI Safety questionnaire to complete. Training will be completed by September 11, 2009.

**Recommendation 8.** We recommended that the VISN Director ensure that the System Director requires MRI technologists to follow up on positive responses on the screening questionnaire and documents actions taken to address potentially dangerous conditions that were identified.

**Concur.**

**Target date of completion:** August 3, 2009

**Planned Action:** There was an Imaging Service Technologist staff meeting 07-31-09 to discuss OIG advisements and appropriate responses. An audit form was created and the MRI Supervisor is conducting random audits of the questionnaire including documentation of actions taken in response to all "yes" answers. Beginning August 3, 2009, all "yes" answers are clarified and stated as "cleared for MRI" by the Technologist.

**Recommendation 9.** We recommended that the VISN Director ensure that the System Director requires Imaging Service managers to develop appropriate consent forms for high-risk patients undergoing an MRI exam with contrast media.

**Concur.**

**Target date of completion:** August 14, 2009

**Planned Action:** IMed Consent signature pads were installed in MRI and the training was completed on 8-14-09. Imaging Service will obtain Informed Consent on all high-risk patients undergoing a MRI with gadolinium contract.

**Recommendation 10.** We recommended that the VISN Director ensure that the System Director addresses the identified training deficiencies.

**Concur.**

**Target date of completion:** See below

**Planned Actions:**

1. All inpatient Behavioral Medicine Ward staff will be trained in identifying and correcting environmental hazards that represent a threat to suicidal patients specific to the Mental Health inpatient unit completed by October 1, 2009.
2. Required infection control training will be completed by all appropriate staff by October 1, 2009.

## **OIG Contact and Staff Acknowledgments**

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